

Central LHIN

Caring Communities – Healthier People: Making a Difference

2008-2009 Annual Report



Ontario

Local Health Integration
Network

CENTRAL LOCAL HEALTH INTEGRATION NETWORK (LHIN 8)

Ontario's 14 Local Health Integration Networks (LHINs) play a critical role as health care in the province evolves into a system that is patient-focused, results-driven, integrated, and sustainable.

Established by the provincial government to plan, coordinate, integrate and fund health service providers – including hospitals, community support service agencies, long-term care homes, community health centres, mental health and addictions agencies and Community Care Access Centres – in their specific geographic areas, LHINs are governed by the Local Health Services Integration Act, 2006. LHINs received full funding authority and responsibility in April 2007.

LHINs possess significant decision-making power at the local level. Guided by local health care issues and challenges, the specific needs of our communities, input from the public and our health service providers, best practices, and Ministry of Health and Long-Term Care priorities, LHINs are helping transform health care – making the changes in our health care system that truly will make a difference in our communities.

In exercising our mandate, LHINs facilitate the effective and efficient integration of health care services, thus making it easier for residents to receive the best care, in the most appropriate setting, when they need it.



Visit www.lhins.on.ca for more information on how LHINs are making a difference.

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Message from the Chair and CEO

Central LHIN's 2008/2009 fiscal year was one of solid accomplishment as we continued our focus on bringing about needed change and building an integrated continuum for health service delivery through collaboration, engagement, and partnerships.

During the year, our ongoing engagement with stakeholders has given us a clear understanding of the importance of a robust and sustainable network of services to meet community needs while ensuring our Integrated Health Services Plan is aligned with the Ministry of Health and Long-Term Care's priorities.

Several accomplishments stand out. In fiscal 2008/2009, we launched 26 health-service provider-led projects through the provincial Aging at Home program. These projects, along with an additional 30 initiatives we will launch in the coming year, are designed to promote innovation and build our capacity so we can better meet the needs of our seniors as we experience greater-than-average population aging over the next 10 years. Part of this strategy focuses on reducing Emergency Room Wait Times and Alternate Level of Care admissions, thus better serving the needs of seniors and relieving some pressure on critical parts of our health care system.

A key component of our transformation activities is the integration of health care delivery. In fiscal 2008/2009, in concert with four other LHINs, Central LHIN released a *Local Health Integration Network/Health Service Provider Governance Resource and Toolkit for Voluntary Integration Initiatives*. This toolkit supports health service provider boards in developing strategies to work with one another and the LHIN on voluntary integration initiatives.

During fiscal 2008/2009, we also undertook a Health Service Needs Assessment and Gap Analysis project to develop a better understanding of our current population and health service needs. This analysis provides us with the data and the

basis to plan for the next 10 years, and will inform our planning activities moving forward.

The report, available on our website, provides a detailed look at Central LHIN's various communities, highlights population characteristics, demographic differences, geographical variations, and urban-suburban-rural attributes integral to local health services planning and delivery.

One area of particular focus is quality. We have identified this as a strategic priority and we will embed a strategic framework for quality and performance improvement in the refresh of our Integrated Health Service Plan. This second iteration of our IHSP, which we refer to as

IHSP-2, will be completed in the fall of 2009.

As part of being accountable for a greater than \$1.5 billion dollar budget, we negotiated and signed 59 two-year Multi-Sector Accountability Agreements. This improved accountability with community sector agencies will help us build a better local health care system and contribute to our quality agenda, much the same as did the two-year Hospital Service Accountability Agreements we negotiated with our seven public and three private hospitals in the last fiscal year.

Finally, we wish to acknowledge and thank our health service providers for their ongoing contribution and dedication, and say a special thanks to our Board and staff for their tireless contributions in supporting the continuing growth and development of Central LHIN. Together, we look forward to an exciting 2009/2010 as we strengthen existing partnerships – and develop new ones – to build a more integrated, sustainable local health system focused on improved health care delivery and better client service.



Ken Morrison
Board Chair,
Central LHIN



Kim Baker
Acting CEO
Central LHIN

Board of Directors



In accordance with the Local Health Systems Integration Act 2006, Local Health Integration Networks (LHINs) operate as not-for-profit organizations governed by an appointed Board of Directors. LHINs are bound by accountability agreements with the Ministry of Health and Long-Term Care.

Each Board member is appointed by an Order-in-Council. Board members are selected based on applications to the Public Appointments Secretariat. All candidates assessed for the fit between their skills and abilities and the needs of the LHIN. Board members are expected to possess relevant expertise, experience, leadership skills, and an understanding of local health issues, needs, and priorities. Members hold office for a term of up to three years and may be re-appointed for one additional term.

The Central LHIN has its full complement of nine Board members including:

Kenneth A. Morrison, Chair	Tenure: June 2, 2005 — June 1, 2011 Location: Newmarket
Arthur W. Walker, FCA, Vice-Chair	Tenure: June 2, 2005 — June 1, 2011 Location: Bradford
Sandy Keshen, Board Secretary	Tenure: June 2, 2005 — June 1, 2011 Location: Richmond Hill
Colin Benjamin	Tenure: January 5, 2006— January 4, 2011 Location: North York
Monique Moreau	Tenure: January 5, 2006 — February 4, 2010 Location: Everett
Raksha Bhayana	Tenure: May 17, 2006 — May 16, 2011 Location: Thornhill
Eugene Cawthray	Tenure: May 17, 2006 — June 16, 2010 Location: King City
Elaine Walsh	Tenure: June 17, 2006 — June 16, 2010 Location: Unionville
John M. Langs	Tenure: September 24, 2008 - September 23, 2011 Location: Toronto

The aggregate remuneration for members of the Board of Directors for fiscal 2008/09 was \$131,000.

Details on the Central LHIN Board of Directors can be found on our website at www.centrallhin.on.ca

Welcome to Central LHIN

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by the provincial government to plan, co-ordinate, integrate and fund health services at the local level. Through our Integrated Health Services Plan (IHSP), which sets out our three-year vision, strategic directions and priorities, Central LHIN is dedicated to improving the accessibility, coordination, quality, and efficiency of our health care system.

A look inside our LHIN

Central LHIN is home to 1.6 million residents, or 12.7% of Ontario's population, up from 11.9% in 2001. Population growth in the LHIN at 6.6% over the next five years and 13.07% in the next 10 years is expected to outpace Ontario's growth rate. Central LHIN has a very diverse geography and population. Its boundaries include the northern section of the City of Toronto, a large portion of York Region, and the southern part of Simcoe County. It is spread over 15 census subdivisions, and shares four of its census subdivisions with other Ontario LHINs, including Toronto Central, Central West and North Simcoe Muskoka.

According to the 2006 census, Central LHIN is the largest of the 14 LHINs in terms of population and third smallest in terms of geographical size, with a population density 40 times greater than that of Ontario as a whole. Approximately 70% of Central LHIN's population live in North Toronto, Vaughan, Richmond Hill and Markham. More than 25% of the population lives in South East York Region. Although the LHIN is primarily urban, it has a significant rural region in the north.

As one way to aid in our planning activities at a local level, Central LHIN divided its geography into seven planning areas, ranging in population from slightly more than 113,257 (South Simcoe, Northern York Region) to 465,683 (South East York Region). These areas have varying age structures, economic conditions, and social characteristics.

Aging and Diversity

Central LHIN will experience greater-than-average population aging over the next 10 years, with the 65-74 age category expected to grow by 56%, the 75-84 age category by 13%, and the 85 and older by 43%. The growing needs of this aging population will significantly impact Central LHIN over the next five to 10 years and beyond.

Central is one of the most ethnically diverse LHINs with the highest proportion of immigrants in the province. These newcomers are concentrated in several municipalities, particularly Toronto, Richmond Hill, Markham, and Vaughan. A total of 37% of Central LHIN's population identify themselves as visible minorities. North Toronto, Markham and Vaughan are the areas most likely to face challenges providing culturally and linguistically appropriate services to these communities.

Individuals whose mother tongue is French account for approximately 1.2% of the Central LHIN's population, while about 0.4% of the population identify themselves as Aboriginals. The LHIN's population tends to be better educated than the provincial average. Of all adults living in the Central LHIN, 61% have post-secondary educations, compared with 56.8 % in Ontario and only 19.9 % of those older than 15 have less than a high school diploma (compared with 22.2 % in Ontario).

Health Profile

Compared with the Ontario average, Central LHIN's population is slightly younger, with only 12.5% over the age of 65 (compared with 13.6% for Ontario). The LHIN also has more low-income families (17.7% versus 14.7% for Ontario).

Generally, the Central LHIN population is healthy with a lower incidence of chronic diseases and conditions such as high blood pressure, diabetes, heart disease, arthritis and asthma than that of Ontario as a whole. Despite this, as the population ages more LHIN residents will develop chronic disease conditions and will have associated changes in their health service needs. Chronic disease conditions place a high burden on the health care system and reduce quality of life.

The Central LHIN's health population profile is reflected in considerably lower hospitalization and death rates than those of the province. The death and hospitalization rates of a community are greatly influenced by its age and gender structure.

Examining Central LHIN's health profile helps us work towards our priority goal of reducing health disparities in our LHIN by identifying high risk populations that would benefit from focused initiatives.

For example, our recent Health Service Needs Assessment and Gap Analysis identified the Aboriginals living in the First Nations Community on Georgina Island as a high risk

population. This community is isolated, is only accessible by water, and within their planning area has:

- the highest concentration of low-income families
- the highest percentage of single-parent families
- the highest percentage of those over the age of 15 with less than a high school education

The most common health issues are obesity and diabetes. It is estimated that more than 75% of Georgina Island children are obese, and the prevalence of obesity in the community is higher than that of Ontario as a whole. Clinic records (administrative data) indicate that 25% of the community has diabetes, most commonly Type II diabetes. The high prevalence of obesity and diabetes is also linked to related health problems, such as heart disease and hypertension in the community.

Central LHIN will continue to engage with this group to determine the most effective ways to address these health inequities. (For more on our engagement with our Aboriginal community, see page 16)

Population Factors Across Central LHIN Planning Areas

	Total Pop. 2008	% Planning Area Pop. in LHIN	% Pop. Aged 65+	% Econ. Family Incidence of Low Income	% Total Lone Parent Families	% Visible Minority Pop.	% Pop. Aged 20+ with less than HS Education
Ontario	12,986,332		13.46	11.33	15.29	20.41	24.60
Central LHIN	1,651,681	12.68	12.36	9.39	15.13	36.72	22.36
South Simcoe and North York Region	113,257	6.86	11.48	6.91	12.60	4.69	28.00
Central York Region	204,207	12.36	10.50	4.84	12.40	8.87	17.32
South East York Region	465,683	28.19	10.46	5.01	11.87	51.57	18.52
South West York Region	230,536	13.96	9.19	3.69	10.47	21.81	22.66
North York West	237,884	14.40	14.80	20.47	26.61	50.41	38.65
North York Central	276,973	16.77	16.91	12.94	16.70	37.78	18.45
North York East	123,141	7.46	14.41	15.28	18.53	55.58	17.86

A Snapshot of the Past Year

Highlights, Initiatives, and Accomplishments

This past year was one of accomplishment and promise for Central LHIN as we made significant strides in our mandate to create a more responsive health system in our community.

Among our 2008-2009 initiatives and accomplishments, we:

- Moved forward on 26 projects under the provincial *Aging at Home* program as part of our goal to ensure seniors have access to the supports and services they need to help them live independently as long as possible. We will follow this up in 2009-2010 with an additional 30 Year 2 Aging at Home initiatives.
- Allocated eight new Dodge Caravans to facilitate and expand – by an additional 1,388 rides/year – transportation *services for seniors* as part of the Aging at Home Provincial Vehicle Purchasing Initiative.
- Made important progress on the crucial *eHealth Strategy* in continued partnership with the Toronto Central LHIN through:
 - establishing a joint LHIN-eHealth Office for the 2008/2009 fiscal year
 - investing in the Physician eHealth initiative, which includes expanding Patient Results Online to five Community Health Centres and/or

- Family Health Teams, and the coordination of a Primary Care eHealth Forum, and
 - investing in the Central LHIN Hospital Data Centre
 - Consolidation Feasibility Study.
- Completed a *Health Service Needs Assessment and Gap Analysis* project to give us a better understanding of Central LHIN's current population and health service needs, as well as an understanding of how those will change over the next decade. This information will inform our planning and funding for the next 10 years, help identify integration opportunities and assist in identifying our priorities
- Partnered with the Faculty of Health at York University on the *Central LHIN Outcome Map* project, which is systematically evaluating Central LHIN's progress toward its vision over a set period of time. The Outcome Map guides our strategies and actions and will be used in system planning with our health service providers
- Negotiated and signed the 2009/2011 *Multi-Sector Accountability Agreements*, with its 59 community agencies, which will hold providers accountable for operating within a balanced budget and maintaining agreed-upon service levels.
- Completed phase one of the development of a *Community of Practice for Diversity* in the Jane-Finch community as a way to help improve awareness and access to health services in that area.
- Launched Central LHIN's *Doorways to Care* toll-free telephone service, designed to help seniors in the LHIN navigate the local community services system and maintain their independence at home for as long as possible. Through Doorways to Care, seniors or caregivers speak to a live operator, and can be referred to multiple agencies at once, depending upon their needs.
- Developed a 2009/2010 *Emergency Department/Alternate Level of Care Overarching Plan* to align the Emergency Room Pay for Results initiative, the Central LHIN Aging at Home Strategy, and our Urgent Priorities Fund initiatives with provincial priorities.
- Developed the *Local Health Integration Network/Health Service Provider Toolkit on Governance Relationships in Voluntary Integration Initiatives*, to support health service provider Boards in developing strategies to work with one another and the LHIN on voluntary integration initiatives.
- Moved forward with a *Health Equity Plan and Policy Development Project*, beginning with the development of a statement of commitment for reducing health disparities: "*Central LHIN will strive to reduce health disparities as a shared responsibility with its health service providers by integrating health equity into strategies and activities within its mandate and influence.*"
- Rolled out the *Ontario Health Based Allocation Methodology* (HBAM) to Central LHIN hospitals for growth funding. HBAM is a LHIN-wide funding formula developed by a joint Ministry/LHIN task force, intended to introduce greater equity and recognition of the costs of delivering health services across all LHINs.
- Invested in a *Polypharmacy Project* as part of an effort to curb the risk of medication mismanagement for seniors. The project was launched by Central Community Care

Access Centre in partnership with SRT Medstaff, COTA Health, York Central Hospital and Southlake Regional Health Centre.

- Welcomed the *Vaughan Community Health Centre* as Central LHIN's newest health service provider, and continued to work with the Ministry of Health and Long-Term Care, and the Vaughan Health Care Foundation to support the continued capital planning for hospital services in Vaughan.

- Approved the *one-time transfer of 1,000 cataract cases* from Humber River Regional Hospital to North York General Hospital for fiscal 2008/2009.
- Invested in the *home hemodialysis program* of York Central Hospital's Chronic Kidney Disease Regional Program to provide home dialysis for an additional 15 patients.

Our Contribution to the Healthcare System

Through our Integrated Health Services Plan, Central LHIN is committed to making a difference by improving the accessibility, coordination, quality, and efficiency of our health system to help people lead healthier lives.

In 2008/2009, Central LHIN allocated a greater than \$1.5 billion budget across 143 health programs, delivered by our more than 100 health service providers. That translates into approximately

\$4.1 million dollars invested in the Central LHIN health system every day.

Central LHIN residents benefited in the last year from an increase in the number of procedures performed by our health service providers, reductions in wait times, and the launch of new services designed to ensure patients receive timely and responsive care in the most appropriate setting.

Central LHIN 2008/9 Health Service Provider Allocation in \$000	
Sector	2008-09 Funding Allocation
Operation of Hospitals	1,002,538
Grants for Municipal Taxation	216
Long Term Care Homes	266,837
Community Care Access Centre	188,132
Community Support Services	31,114
Acquired Brain Injury	8,561
Assisted Living Services in Supportive Housing	18,652
Community Health Centres	4,897
Community Mental Health	54,504
Addictions Program	4,294
Total	1,579,748

Additional Procedures:

In order to improve access to key priority areas the CLHIN invested \$ 36,036,494 in additional one-time funding, to enable our hospitals to increase the number of procedures performed over what was initially budgeted for.

In 2008/2009 Central LHIN's health care providers performed:

- ✓ 925 more cardiac procedures
- ✓ 4,044 more cataract surgeries
- ✓ 465 more cancer surgeries
- ✓ 1,356 more hip/knee joint replacements

And added:

- ✓ 21,533 more MRI hours
- ✓ 1,618 more CT hours

Wait Time Reductions:

In 2008/2009:

- ✓ Cataract surgery wait times *down* by 3.5%
- ✓ MRI scans wait times *down* by 10%
- ✓ Hip replacement wait times *down* by 15.5%
- ✓ Knee replacement wait times *down* by 13.3%

Initiation of New Services:

In 2008/2009, Central LHIN initiated:

- ✓ ***Outreach Services to Homebound Seniors.***

These additional, in-community supports are designed to delay or prevent admissions to long-term care homes.

- ✓ ***Community Alternatives to Long-Term-Care Placement.*** Through a partnership with our Community Care Access Centre and the community support sector, this program targets seniors on long-term care wait lists who could be maintained at home with a flexible variety of services.

- ✓ ***ER Pay for Results program – Year 1.***

Through this program, Central LHIN works with our hospitals to reduce wait times and improve services in emergency departments.

And added:

- ✓ 30 new *Convalescent Care Beds* and nine *Interim beds* in three long-term care homes to allow more seniors to be discharged from hospital to a more appropriate setting.

Ministry-LHIN Accountability Agreement

Purpose of the Ministry-LHIN Accountability Agreement

The Central LHIN has negotiated and signed an accountability agreement with the Ministry of Health and Long-Term Care, which defines the obligations and responsibilities of both the LHIN and the Ministry for 2007/08 to 2009/10. This *Ministry-LHIN Accountability Agreement* outlines what is expected of our LHIN in these areas: Community Engagement, Planning and Integration, Local Health System Management, Financial Management, Local Health System Performance, and eHealth.

Central LHIN Ministry-LHIN Accountability Agreement Performance 2008/09

The *Ministry-LHIN Accountability Agreement* clearly defines the relationship between the Ministry of Health and Long-Term Care and the Central LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN, and outlines respective performance indicators within a pre-defined period of time. Over the past year, we measured our impact through the following performance indicators:

Performance Indicator	LHIN 08/09 Starting Point	LHIN 08/09 Target	Most Recent Quarter 2008/09*	Annual** Results	LHIN Met Target YES/NO
90th Percentile Wait Times for Cancer Surgery	55	51	52	49	YES
90th Percentile Wait Times for Cardiac By-Pass Procedures	68	60	46	58	YES
90th Percentile Wait Times for Cataract Surgery	110	110	82	80	YES
90th Percentile Wait Times for Hip Replacement	183	182	142	147	YES
90th Percentile Wait Times for Knee Replacement	217	195	169	166	YES
90th Percentile Wait Times for Diagnostic MRI Scan	110	105	99	100	YES
90th Percentile Wait Times for Diagnostic CT Scan	46	42	39	30	YES
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC) ³³	210.00	210.00	185.01	186.28	YES
Median Wait Time to Long-Term Care Home Placement -All Placements ³⁴	63.00	55.00	115.00	94.00	NO
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution ³⁵	9.80	9.60	14.18	12.18	NO
Rate of Emergency Department Visits that could be Managed Elsewhere ³⁶	9.47	9.40	7.28	7.37	YES
Readmission Rates for Acute Myocardial Infarction (AMI) ³⁷	3.80	3.80	3.24	3.35	YES

*Performance indicators 1-7 = Q4 2008/09; and 8-12=Q3 2008/09

**Performance indicators 8-12 (in the Annual Results Column) only include the average of Q1-3

Note: The success of Central LHIN in meeting performance targets for each MLAA indicator (YES/NO, as per last column) is assessed taking into account an upper limit performance corridor (i.e. performance target + X%).

Meeting our Performance Goals

Wait times for care or services is sometimes said to be the most challenging issue in the health system. Lengthy wait times for things like emergency care, or procedures such as cataract surgery, or hip and knee replacements can negatively affect a patient's overall care experience and their ultimate outcome. This is why wait times remain both a provincial and a Central LHIN focus.

In 2008-09, Central LHIN continued to allocate funding for wait times to areas where it was most needed. We've worked with our health

service providers to manage the wait lists, invested strategically in areas where it will make tangible improvements in wait times, and we monitored our progress on a monthly basis in order to take timely action if necessary.

In alignment with the provincial Wait Times Strategy, we've brought wait times in Central LHIN down for a range of critical procedures including: Bypass surgery, Cataract Surgery, Hip replacement, Knee replacements, MRI exams, CT scans, general surgery, and pediatric surgery. Our allocations have in particular

resulted in higher volumes for cataract and hip/knee replacement procedures, and more hours for MRI and CT scans.

Despite the actions identified above, the Central LHIN was not able to meet the Ministry LHIN Accountability Agreement targets for Alternate Levels of Care and Median Wait Times for Long-Term Care. Some of the challenges that contributed to this include a lack of capacity in long-term care, high utilization rates and the diversity (age and demographic) in our LHIN, which limits placement options.

To address these targets, we have invested in our Alternate Level of Care strategy – through both the Aging at Home program and the LHIN Urgent Priorities Fund – which focuses on providing interim beds and increasing capacity in the system to help alleviate backlogs and pressures in the acute care area.

(For more on Aging at Home, see page 14. For more on our Alternate Level of Care activities within the LHIN Urgent Priorities fund, see page 19).

Investing in additional procedures

Over the past year, \$ 36,036,494 has been invested through the Wait Time Strategy for additional procedures in Central LHIN hospitals including:

Procedure	Incremental* funding	Resulting in an additional
Cataracts	\$2,826,100	4,044 cataract surgeries
Cardiac	\$14,629,341	925 cardiac procedures
Hip and Knee Joint Replacements	\$9,173,400	1,356 joint replacements
Cancer	\$3,404,473	465 cancer surgeries
MRI	\$5,598,580	21,533 hours
CT	\$404,600	1,618 hours

Table: For April 1 2008- March 31 2009

*Incremental funding is one-time funding allocated to a hospital to provide a certain number of additional procedures within a specific year.

Working with our health service providers

High volume cataract centres – Central LHIN's Wait Times Strategic Planning Group developed a strategy to implement two high volume cataract centres - one in the north and one in the south area of the LHIN. This would result in a number of positive benefits for patients, including better clinical outcomes, shorter overall wait times for surgery, and enhanced capacity within the system to deliver more surgeries each year. The first of these

integrations has taken place, as volumes for cataract surgeries at York Central Hospital have now moved to Southlake Regional Health Centre.

Improving productivity and efficiency for MRIs

– As part of the Provincial MRI Efficiency Project, Central LHIN has supported the development of a tool known as an MRI Dashboard. Facilitated through Humber River Regional Hospital, this tool monitors vital statistics and key performance indicators

developed by the hospital in conjunction with the project team including:

- Efficiency
- Capacity
- Wait Times
- Variable Cost
- Staff Satisfaction

Total Joint Assessment Centre (TJAC) –

Central LHIN continues to support this integration initiative amongst three of its hospitals: Markham Stouffville Hospital, North York General Hospital and York Central Hospital. The goal of TJAC is to better meet the population needs of the catchment areas served by the hospitals by streamlining referrals and pre-surgical assessment of patients experiencing

hip or knee joint pain. The benefits of this approach include: reduced wait times for joint replacements, improved quality of care through enhanced coordination and delivery of service, more choice for the patient, and an increase in numbers of procedures done.

As Central LHIN continues to promote and implement these types of proactive solutions, as well as monitor and track our progress in this area, we are confident our residents will continue to benefit from reduced wait times in our LHIN.

Our Integrated Health Service Plan

Making a Difference with our IHSP

Central LHIN released its first Integrated Health Service Plan (IHSP) in November 2006. The IHSP is a three-year plan outlining the Central LHIN's health care priorities, based on dialogue and consultation with health service providers and health care consumers.

In order to realize improvements in the four system goals of access, coordination, quality and efficiency, our IHSP focused on seven priorities identified by residents and health service providers:

- Improving services for seniors
- Help for mental health and addictions
- Supporting neurological services
- Managing chronic disease
- Reducing wait times
- Accessing emergency services
- Access to cancer care services

The plan outlined a three-year vision for improving the Central LHIN health service system and specific priorities for action. Through the Aging at Home program, we made significant progress within our seniors priority, (as outlined in the next section of this report). We have also made progress in other priority areas including managing chronic disease, reducing wait times, and accessing emergency services

Looking Ahead to IHSP-2 – Refocusing our priorities

In February 2009, Central LHIN began to refresh and refocus its 2006 IHSP, through a Steering Committee of representatives from different health service providers including: hospitals, the Community Care Access Centre (CCAC), community providers of care, clinicians, and primary care representatives.

Dubbed IHSP-2, this next iteration of our IHSP will build on the 2008 work of the Health Service Needs Assessment and Gap Analysis project, which engaged our health service providers and community representatives to work with us to assess and identify the long-term health service needs within the Central LHIN.

This initiative will help ensure we take into account both the current and future health service needs of our communities as we plan and develop solutions. The IHSP refresh will also align with Ministry provincial priorities and strategies.

Three Citizens Reference Panels have been scheduled to support the IHSP refresh process and to obtain community stakeholder feedback, after which the Central LHIN staff will recommend IHSP-2 to the Central LHIN Board of Directors for approval in the fall of 2009.

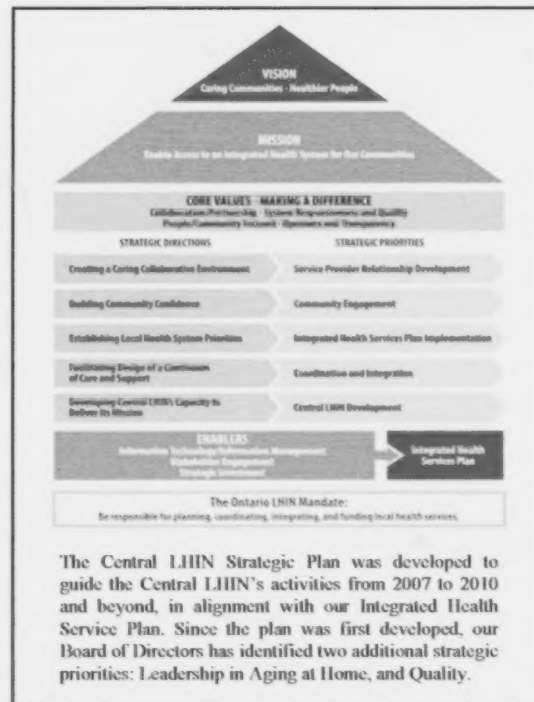
Implementation of the IHSP

Seniors are the fastest growing segment of the Central LHIN population. In August 2007, the Ministry of Health and Long-Term Care announced a \$700 million Aging at Home strategy aimed at providing the supports and services seniors need to live independently in the community for as long as possible.

Under this program, Central LHIN will invest \$106 million over three years, including:

Year	Investment*
2008/09 (Year 1)	\$13.5M
2009/10 (Year 2)	\$33.6M
2010/11 (Year 3)	\$59.3M

*These amounts include yearly base increases to the system



Innovation

In keeping with the Ministry's determination that at minimum 20 percent of Year 1 projects meet their innovation criteria, Central LHIN introduced some truly innovative initiatives in the areas of supportive housing, wellness and prevention, and reducing language barriers.

Overall Increase in Services to Seniors through Aging at Home

Central LHIN's Aging at Home initiatives targeted these areas of focus:

- Transportation
- Specialized Geriatric Services for Seniors
- Patient Safety
- Supportive Housing
- Community Supports for Independent Living
- Emergency Department Management
- Convalescent Care Bed Expansion

The following table highlights the overall total increase in services provided:

SERVICE	TOTAL SERVICE IMPACT
Clients served	3005
Hours of service	18463
New Referrals to programming	1350
One-way transportation rides	10474
Meals	1698
Clients Diverted from the Emergency Department	423
Comprehensive In-Home Pharmacist Assessments	70
Caregiver counselling and support hours	5748
Client counseling and support hours	829
Supportive Housing Units	50
Convalescent Care and Interim Beds	39

Our health service providers also reported 82.5 full-time equivalent staff hires under Aging at Home 2008/09 (Year 1).

Aging at Home Highlights

Geriatric Emergency Management Expansion

Central LHIN provided five new Geriatric Emergency Management nurses in six hospitals. These nurses increase the capacity of health providers both within the Emergency Departments and the region, helping address the complex needs of the frail elderly. More than 300 patients have been seen by Geriatric Emergency Management nurses, 232 clients were admitted to Community Care Access Centre and 114 referrals were made to Specialized Geriatric Services.

Community Alternatives to Long-Term-Care Placement

Central LHIN enabled enhanced community support services delivered through a partnership between the Central Community Care Access Centre and the Community Support Service sector. These services targeted seniors on a long-term-care waitlist who could be maintained at home with a flexible menu of support services. Clients received additional services such as Day

Programs (36 clients), Meals (1,600 Meals on Wheels) and transportation.

Extreme Cleaning

Central LHIN funded this program to provide cleaning services for vulnerable seniors living with mental illness, who are at risk eviction. A total of 86 clients were served and as a result were able to stay at home in a healthy and safe environment.

Collaborative Community Referrals by Emergency Medical Services

Central LHIN facilitated the expansion of emergency medical services to include timely referrals to community services for seniors who do not require hospital based services in York Region and South Simcoe. This has reduced the number of inappropriate emergency department admissions. More than 400 clients were diverted from the Emergency Department through 198 nursing visits, 1,193 Personal Support Worker visits and 150 Occupational Therapy visits.

Home at Last

Central LHIN selected this program to provide transportation escort services and personal support assistance to clients who require assistance upon hospital discharge, allowing clients to be safely discharged earlier. More than 1,526 clients were served by Home at Last.

Increased Convalescent Bed Capacity

Central LHIN developed 30 new convalescent care beds in long-term care homes. These beds provide more appropriate placement for seniors who are not ill enough to remain in hospital, but who are not quite well enough to return to their homes in the community.

Outreach Teams to Homebound Seniors

Central LHIN facilitated the development of two new multidisciplinary geriatric outreach teams for frail seniors living in their own homes. More than 50 clients have been served with 61 new referrals. As a result, social workers have enhanced their expertise after working closely with clinicians and can handle more complex cases.

Connecting with our Communities

Our Commitment to Community Engagement

Community engagement is an integral part of Central LHIN's activities. By listening to our residents, local health service providers, and strategic partners, and by seeking input into our plans, we support community-level participation in health system decision making.

We have made – and will continue to make – efforts to reach greater numbers of LHIN residents to include them in meaningful discussion about the changes needed in our health system and how best to make them.

LHINs Evaluation Tools

The LHINs agree on the need for more robust evaluation tools that can comprehensively assess the impact of their engagement strategies on their communities. The development of a common community engagement framework is the first, critical step in the development of common assessment tools. A McMaster

University-led research initiative is developing a common community engagement framework that will include shared goals, effectiveness indicators, and an evaluation instrument. This framework will be piloted in several LHINs.

Health Service Needs Assessment and Gap Analysis

As part of the Health Service Needs Assessment and Gap Analysis, we used a number of engagement techniques to elicit feedback. The process was overseen by an advisory committee of various health service providers. The committee held interviews with about 20 senior hospital leaders and /or executive teams. In addition, committee members made presentations to elicit comments from the majority of the LHINs advisory committees and networks. We also held six priority focus group sessions on Emergency Department issues, Seniors Care, Mental Health and Addiction, Cancer and Cardiac Services and Chronic

Disease Management, and seven sessions in different regions across the LHIN to examine the LHINs planning areas.

Hospital Community Engagement

As part of the Central LHIN's Hospital Accountability Agreements, our hospitals collaborated with each other and with other health service providers to develop a community engagement strategy to inform their:

- strategic planning
- integration efforts
- Hospital Annual Planning Submission

We established a task group to facilitate this process as well as a strategy and guidelines for engagement and community engagement implementation plans.

Citizens Workshop on Engagement and Health-Engaging with Impact

Last year the Central, South East and North West LHINs worked with Mass LBP – a company that helps organizations improve their efforts to engage and consult with residents – to develop a Citizens Workshop. The goal: to garner advice that would help both the LHINs and the Ministry in improving their efforts to engage with residents and better meet their expectations. The LHINs invited residents to spend a day with them to learn about their work and their region's health system. The workshops resulted in a report outlining recommendations and indicators that can be used to evaluate performance and develop a culture of engagement.

Back Office Forum

Central LHIN partnered with Bethany Lodge on a project to examine the feasibility of integrating finance and group purchasing for 30 community providers from the Community Support Service and Community Mental Health and Addictions

sectors. We surveyed their requirements and held focus groups to determine their preferences from among three integration models. This data will be used to determine feasibility and provide ideas for moving forward.

Connecting with our Physicians

Although physicians fall outside of the mandate of our LHIN, we recognize their crucial role in the health system. This past year we met with more than 80 physicians to discuss creating stronger working relationships, better communications, and partnerships to improve patient care. We will continue this dialogue in order to explore further opportunities for collaboration

Governance Councils

Central LHIN held eight Governance Council meetings, to continue to develop relationships between members of the Board leadership of Central LHIN and the Board Chairs of our health service providers.

Six meetings were organized geographically (Central Region, South Region, and North Region) for community agency health service provider board chairs, with two Hospital Governance Councils. These meetings help to keep Board Chairs updated on Central LHIN's current activities and progress, give participants a chance to investigate new ways to work together, and provide a forum to discuss new ideas, governance level priorities, challenges and opportunities.

Discussions around key topics included:

- Roll-out of the *LHIN/Health Service Provider Governance Resource and Toolkit for Voluntary Integration Initiatives*,
- The launch of the Ontario Health Based Allocation Methodology,

- The completion of the 2009/2011 Multi-Sector Accountability Agreements negotiation process for our 59 community agencies, and
- Updates on the progress of our Health Service Needs Assessment and Gap Analysis.

(More detail on each of these topics is contained in *Highlights, Initiatives, and Accomplishments* on page 6-8 of this Annual Report.)

Connecting with our Aboriginal Population

The Ministry has provided LHINS with additional annual funding to engage with the Aboriginal population. Central LHIN used its allocation to contract the Noojimawin Health Authority, a Toronto-based Aboriginal health planning organization, to:

- identify the Aboriginal population's health priorities
- identify key contacts within the Aboriginal communities
- determine the most effective way to engage these key people, and,
- provide information about the LHIN

We held a focus group session on Georgina Island as part of the Health Service Needs and Gap Analysis project to identify Aboriginal health priorities and to subsequently develop a strategic plan to address diabetes and obesity health priorities.

Additionally, a team of LHIN community engagement leads from the Greater Toronto

Area held a workshop in early 2009 to determine ways to meet the Ministry of Health and Long-Term Care's planning and engagement regulations. Central LHIN initiated a project funded by the Aboriginal Health Transfer Fund that would explore how the service delivery of health service providers can better meet the needs of Aboriginal people.

Connecting with our Francophone Population

Francophones make up 1.2 percent of the Central LHIN population. In the past year, the francophone community participated in both the Aging at Home and the Health Service Needs Assessment and Gap Analysis engagement sessions. These sessions were designed to:

- share information about Central LHIN activities
- discuss current French language services, including needs and gaps
- discuss how to achieve a shared vision for French language services in Central LHIN

We also conducted a survey with those Central LHIN health service provider who identified they served French speaking clients, to determine their French language service capabilities. In addition to helping us determine the current geographical distribution of French-speaking services and programs in the LHIN, this information will help efficiently target potential future French-language service training opportunities, programs, and funding.

Integration Activities

Promoting and Supporting Integration

Key to the LHINs' mandate is promoting integration in Ontario's health care system. Integrated health systems provide coordinated, accessible, and high-quality health care that

focuses on client needs, improves patient care, and makes service delivery more efficient. Here's a snapshot of Central LHIN integration activities that were initiated in 2008/2009.

Integration Name	Type*	Description / Partners
Matthews House Hospice - Divestment from Hospice Simcoe to Hospice Alliance	Facilitated	Transfer of funding for Matthews House Hospice from Hospice Simcoe in North Simcoe Muskoka LHIN to Hospice Alliance in Central LHIN, to align its funding and enable future partnerships with other hospices in Central LHIN
Stevenson Memorial Hospital/Southlake Regional Health Centre Clinical & Obstetric Collaborative	By Funding	Create administrative and clinical obstetric collaborative to be more efficient and to promote clinical- and support service improvements
My Friend's Place Divestment from Consumer Survivor Project Simcoe County to the Krasman Centre	Facilitated	Transfer funding for My Friend's Place from the Consumer Survivor Project Simcoe County in North Simcoe Muskoka LHIN to the Krasman Centre in Central LHIN, to improve the quality and extent of peer support programming in South Simcoe
North York Central Meals Merger with Wheels/ Don Mills Foundation	Voluntary	Merge North York Central Meals on Wheels with Don Mills Foundation for Seniors, to be more efficient and serve more clients
York Central Hospital/Southlake Regional Health Centre Cataract Surgery Collaboration	Voluntary	Transfer cataract surgery base volumes from York Central Hospital to Southlake Regional Health Centre to create capacity for more procedures and decrease wait times for surgery

*A complete description of the different types of integration is contained in the *Local Health System Integration Act*, 2006, available at www.centrallhin.on.ca, under "Ontario LHINs."

Governance Resource and Toolkit for Voluntary Integration

The *LHIN/Health Service Provider Governance Resource and Toolkit for Voluntary Integration Initiatives* supports health service provider Boards in developing strategies to work with one

another and the LHIN on voluntary integration. The toolkit is available on the Central LHIN website at www.centrallhin.on.ca.

LHIN Initiatives in Support of Government Priorities

Improving Emergency Department Wait Times

In May 2008, the Ministry of Health and Long Term Care announced a \$39.5 million "Performance Fund" initiative for the 23 Ontario hospitals facing the longest Emergency Department wait times. Central LHIN received \$4,648,220 for North York General Hospital, Humber River Regional Hospital (Finch and Church sites) and York Central Hospital.

The hospitals submitted action plans outlining their initiatives and these performance targets:

- Emergency Department Length of Stay may exceed 24 hours for no more than 2% of the Emergency Department's total patient volume
- A 5% decrease in wait times for the patients classified* as most severe
- Improvement in the proportion of patients treated within four hours for patients classified as less urgent and non urgent

In January 2009, the Ministry announced to the LHINs, province-wide funding of \$55 million for year two of this initiative, now known as the Emergency Department Pay for Results initiative. Central LHIN was allocated \$7,851,140. This funding is intended to be used to reduce emergency department length of stay and improve patient satisfaction at these six hospital sites: Humber River Regional Hospital (Finch and Church sites); Markham Stouffville

Hospital; North York General Hospital; Southlake Regional Health Centre, and York Central Hospital.

Performance targets for year two were:

- 10% improvement in the proportion of admitted patients treated within eight hours
- 10% improvement in the proportion of non-admitted high acuity patients treated within six hours for patients classified* as less urgent and non urgent and less than eight hours for patients classified as most severe
- 10% improvement in the proportion of non-admitted patients treated within four hours for patients classified as less urgent and non urgent

In addition to these indicators, the Central LHIN requested the hospitals include an additional indicator:

- Patient Left without Being Seen/Patient Left against Medical Advice to be less than or equal to 4% of the Emergency Department's total patient volume.

Data on the results of the first year of the Emergency Department Pay for Results initiatives will be complete by July 2009. Central LHIN continues to partner with the six hospital sites (for year two) to support them in achieving their performance targets.

* Patients are classified under the Canadian Triage Acuity Scale as: *Resuscitation*, conditions that are threats to life or limb (or imminent risk of deterioration) requiring immediate aggressive interventions; *Emergent*, conditions that are a potential threat to life limb or function, requiring rapid medical intervention; and *Urgent*, conditions that could potentially progress to a serious problem requiring emergency intervention.

Improving the Alternate Level of Care Situation

In 2008/09, the Ministry allocated \$3.6 million to Central LHIN from the provincial Urgent Priorities Fund to address local priorities.

In keeping with Ministry's strategic priority and Central LHIN's Integrated Health Services Plan, we invested much of these funds on our Alternate Level of Care strategy, which focuses on providing interim beds and increasing capacity in the system to help alleviate backlogs and pressures in the acute care area.

Increasing Interim Beds

As part of our strategy, one of Central LHIN's key initiatives is to increase the supply of interim beds to help provide timely and manageable care for patients waiting in acute care beds at the hospitals. As an example, Central LHIN provided funding to open nine interim beds at River Glen Haven long-term care home.

Increasing Rehabilitation Capacity

In order to facilitate acute hospital transfers to decrease alternate level of care occupancies in our hospitals, and improve wait times for rehabilitation services, we also invested funds to

increase patient intake capacity for rehabilitation services.

Increasing Home Care Services

As a third component of the strategy, Central LHIN provided funding to the Central Community Care Access Centre to support those on the waiting list for long-term care in two ways:

Wait at Home:

Patients in Emergency Departments and on inpatient units who are awaiting long-term care home placement and who meet the *Wait at Home* program criteria, are given the option of returning to their own home for a period with an enhanced package of in-home and community support services while they wait for a long-term care bed.

Stay at Home:

Provisions are made for Community Care Access Centre clients who require a variety of enhanced services to avoid unmanaged health crises or inappropriate Emergency Department visits while waiting at home for admission to a long-term care home.

Special Initiatives

Quality a Strategic Priority

The Central LHIN Board of Directors has long identified Quality as a strategic priority, and in 2008/2009 we undertook some key initiatives in this area.

As a first step in defining our role and responsibilities in developing a system-level approach to quality, Central LHIN conducted a comprehensive review of the status of quality with its health service providers, including definitions and frameworks, and their current quality performance indicators.

We completed a stakeholder survey with 53 Central LHIN health service providers, which provided a snapshot of quality in Central LHIN. Overall, the survey found that the majority of respondents were already actively engaged in quality initiatives.

We then developed a Quality Action Plan and Guiding Principles for moving the quality agenda forward in conjunction with our stakeholders.

Central LHIN has also adopted the Ontario Health Quality Council framework for quality, which outlines nine attributes of a high performing health system. This framework helps us define what we mean by "quality", and will help guide the development of future quality measures at the system level:

"The people of Ontario have a common vision of a high performing health system that is: accessible, effective, safe, patient-centred, equitable, efficient, integrated, focused on population health and has the appropriate resources to get the job done."

Central LHIN continues to collaborate with other LHINS (with the assistance of the Institute for Healthcare Improvement) to pilot the Triple Aim quality model in LHIN planning and outcome measurement. The Triple Aim model focuses on three key areas of quality: health of a defined population; experience of care; and per capita cost.

As our IHSP outlines our strategic priorities going forward, the Central LHIN has also tasked our IHSP-2 Steering Committee with ensuring quality is embedded within the plan.

Health Equity

Both the Health Service Needs Assessment and Gap Analysis and the Integrated Health Services Plan identified the need for health equity and reducing health disparities within our health care system as important components. To support the Health Equity agenda, we established a Diversity and Inclusion Advisory Group and a Health Equity Collaborative Task Group, which advises the LHIN and provides feedback on our health equity initiatives. They also identify further health equity opportunities for consideration.

A key milestone in our progress in this strategic priority has been the development of a Board-approved Health Equity Mission Statement to ensure that health equity is embedded in the planning and delivery of services across Central LHIN:

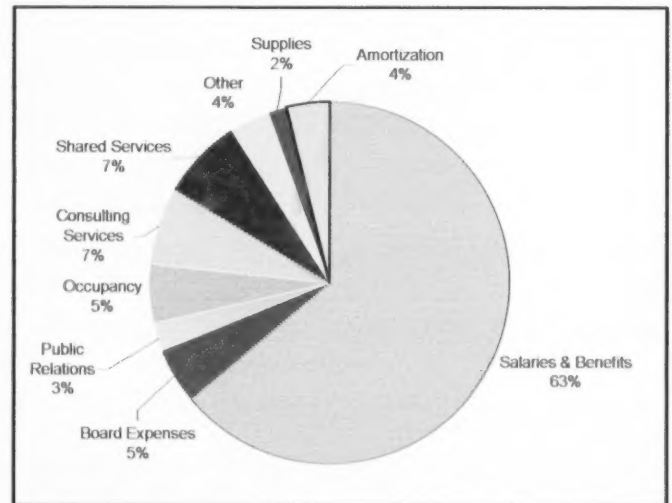
"Central LHIN will strive to reduce health disparities as a shared responsibility with its health service providers by integrating health equity into strategies and activities within its mandate and influence."

Operational Performance

The Central LHIN Operating Budget for 2008-2009 comprised two components:

Operations: \$4.2 million
Special Projects: \$639,000

Most of the \$4.2 million operations budget was used to cover Central LHIN's Salaries and Benefits. The second largest expense was the LHIN Shared Services Office, which provides payroll, technology, and legal services for all 14 LHINs.



Special Projects

During fiscal 2008-2009, Central LHIN received one-time funding to plan and develop four special projects:

eHealth	\$483,700
Emergency Department Lead	\$ 75,000
Aboriginal Engagement	\$ 47,088
Emergency Room-Alternate Level of Care	<u>\$ 33,300</u>
Total:	\$639,088

Auditors' Report

To the Members of the Board of Directors of the
Central Local Health Integration Network

We have audited the statement of financial position of the Central Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Central Local Health Integration Network as at March 31, 2009 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

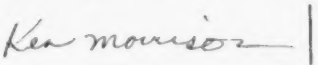
Chartered Accountants
Licensed Public Accountants
May 1, 2009

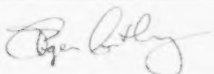
Central Local Health Integration Network

Statement of financial position
as at March 31, 2009

	2009	2008
	\$	\$
Financial assets		
Cash	605,733	671,821
Due from Ministry of Health and Long-Term Care ("MOHLTC")	5,981,119	3,054,920
Accounts receivable	98,470	2,725
	6,685,322	3,729,466
Liabilities		
Accounts payable and accrued liabilities	683,054	601,969
Due to MOHLTC (Note 3b)	-	70,733
Due to Health Service Providers ("HSPs")	5,981,119	3,054,920
Due to the LHIN Shared Services Office (Note 4)	21,149	1,844
Deferred capital contributions (Note 5)	325,793	303,746
	7,011,115	4,033,212
Commitments (Note 6)		
Net debt	(325,793)	(303,746)
Non-financial assets		
Capital assets (Note 7)	325,793	303,746
	325,793	303,746
Accumulated surplus	-	-

Approved by the Board

 Director

 Director

Central Local Health Integration Network

Statement of financial activities year ended March 31, 2009

		2009	2008
	Budget (unaudited) (Note 8)	Actual	Actual
	\$	\$	\$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 8)	1,540,474,300	1,579,748,869	1,493,039,609
Operations of LHIN	4,259,237	4,073,224	3,436,912
E-Health (Note 10a)	130,000	483,700	275,000
Emergency Room/Alternative Level of Care ("ER - ALC") Funding (Note 10b)	-	33,300	-
Aging at Home Funding (Note 10c)	-	-	263,000
Aboriginal Initiative (Note 10d)	-	47,088	10,000
Vaughan Hospital Study	-	-	350,000
Governance Toolkit (Note 10e)	-	-	50,000
Emergency Department Lead (Note 10f)	-	75,000	31,300
Wait Time Funding (Note 10g)	-	-	70,000
Amortization of deferred capital contributions (Note 5)	-	164,044	120,381
	1,544,863,537	1,584,625,225	1,497,646,202
Expenses			
Transfer payments to HSPs (Note 9)	1,540,474,300	1,579,739,110	1,492,904,011
Operations			
General and administrative (Note 11)	4,259,237	4,237,268	3,556,988
E-Health (Note 10a)	130,000	483,700	275,000
ER - ALC funding (Note 10b)	-	33,300	-
Aging at Home Funding (Note 10c)	-	-	263,000
Aboriginal Initiative (Note 10d)	-	47,088	10,000
Vaughan Hospital Study	-	-	350,000
Governance Toolkit (Note 10e)	-	-	50,000
Emergency Department Lead (Note 10f)	-	75,000	31,300
	1,544,863,537	1,584,615,467	1,497,440,299
Annual surplus before funding adjustments for unallocated in year recoveries from HSP's	-	9,759	205,903
Adjustments for unallocated in year recoveries from HSP's (Note 3a)	-	(9,759)	(135,598)
Funding repayable to the MOHLTC regarding operations (Note 3a)	-	-	(70,305)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Central Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2009

	2009	2008
	\$	\$
Annual surplus	-	-
Acquisition of capital assets	186,091	63,691
Amortization of capital assets	(164,044)	(120,381)
Change in other non-financial assets	-	(3,490)
Decrease in net debt	22,047	(60,180)
Opening net debt	303,746	363,926
Closing net debt	325,793	303,746

Central Local Health Integration Network

Statement of cash flows

year ended March 31, 2009

	2009	2008
	\$	\$
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	(164,044)	(120,381)
Amortization of deferred capital contributions (Note 5)	164,044	120,381
	-	-
Changes in non-cash operating items		
Increase in due from MOHLTC	(2,926,199)	(3,054,920)
Increase in accounts receivable	(95,745)	(2,493)
Increase in accounts payable and accrued liabilities	81,085	322,033
(Decrease) increase in due to the MOHLTC	(70,733)	70,305
Increase in due to HSPs	2,926,199	3,054,920
Increase (decrease) in due to the LHIN Shared Services Office	19,305	(33,073)
Decrease in prepaid expenses	-	3,490
	(66,088)	360,262
Capital transactions		
Acquisition of capital assets	(186,091)	(63,691)
Financing transactions		
Increase in deferred capital contributions (Note 5)	186,091	63,691
Net (decrease) increase in cash	(66,088)	360,262
Cash, beginning of year	671,821	311,559
Cash, end of year	605,733	671,821

Central Local Health Integration Network

Notes to the financial statements

March 31, 2009

1. Description of business

The Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and the amounts transferred to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2008.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of North York, York Region and South Simcoe. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, and they are measurable. Expenses include non-cash items, such as the amortization of capital assets; and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN financial statements do not include any MOHLTC managed programs, where the HSP is directly accountable to the MOHLTC.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2009

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund capital asset purchases, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment and development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2009

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

- a. Excess funding from the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	2009 surplus	2008 surplus
	\$	\$	\$	\$
Transfer payments to HSPs	1,579,748,869	1,579,739,110	9,759	135,598
LHIN operations	4,237,268	4,237,268	-	305
Special Program Funding	639,088	639,088	-	70,000
	1,584,625,225	1,584,615,466	9,759	205,903

Transfer Payment funding of \$9,759 (2008 - \$135,598) was not fully allocated. The \$9,759 (2008 - \$135,598) is made up of unallocated in year recoveries from HSPs and is retained by the MOHLTC.

- b. The amount due to the MOHLTC at March 31 is made up as follows:

	2009	2008
	\$	\$
Due to MOHLTC, beginning of year	70,733	428
Funding repaid to MOHLTC during the year	(70,733)	-
Funding repayable to the MOHLTC related to current year activities	-	70,305
Due to MOHLTC, end of year	-	70,733

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2009

5. Deferred capital contributions

	2009	2008
	\$	\$
Balance, beginning of year	303,746	360,436
Capital contributions received during the year	186,091	63,691
Amortization for the year	(164,044)	(120,381)
Balance, end of year	325,793	303,746

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next four years and thereafter are as follows:

	\$
2010	258,010
2011	258,010
2012	258,010
2013	258,010

The LHIN enters into accountability agreements with HSP's which include planned funding targets. The actual amounts which will ultimately be paid to HSP's are contingent on LHIN funding received from the MOHLTC.

7. Capital assets

			2009	2008
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office furniture and fixtures	253,050	139,559	113,491	95,665
Computer equipment	60,958	22,798	38,160	23,808
Leasehold improvements	495,058	320,916	174,142	184,273
	809,066	483,273	325,793	303,746

Central Local Health Integration Network

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8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2008. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of \$ 1,579,748,869 is made up of the following:

	\$
Initial budget	1,540,474,300
Adjustments due to announcements made during the year	39,274,569
	<u>1,579,748,869</u>

The total budget by sector is as follows:

Operation of Hospitals	1,002,538,075
Grants for Municipal Taxation	216,450
Long Term Care Homes	266,837,701
Community Care Access Centres	188,132,223
Community Support Services	31,114,927
Acquired Brain Injury	8,561,178
Assisted Living Services in Supportive Housing	18,652,036
Community Health Centres	4,897,912
Community Mental Health	54,504,176
Additions Program	4,294,191
Total budget	<u>1,579,748,869</u>

The original operating budget was \$4,259,237. Additional program funding in year resulted in a year-end budget of \$4,876,356 made up of the following:

	\$
Initial budget as reported on the statement of financial activities	4,259,237
Additional funding received in-year:	
Funding for capital asset purchased transferred to deferred capital contributions	(186,091)
Funding transferred from deferred capital contributions	164,044
Special programs	
E-health	483,700
Aboriginal Initiative	47,088
Emergency Response - Alternate Level of Care	33,300
Emergency Department Lead	75,000
Closing Budget	<u>4,876,278</u>

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9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$1,579,748,869 (2008 - \$1,493,039,609) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2009 as follows:

	2009	2008
	\$	\$
Operation of Hospitals	1,002,538,075	952,972,962
Grants to compensate for Municipal Taxation		
- Public Hospitals	216,450	216,450
Long Term Care Homes	266,837,701	256,892,671
Community Care Access Centres	188,132,222	170,737,908
Community Support Services	31,105,167	33,803,924
Acquired Brain Injury	8,561,178	-
Assisted Living Services in Supportive Housing	18,652,036	18,271,900
Community Health Centres	4,897,912	3,300,771
Community Mental Health	54,504,178	52,782,133
Addictions program	4,294,191	3,925,292
	1,579,739,110	1,492,904,011

10. a) E-health

The LHIN received funding of \$483,700 (2008 - \$275,000) related to the E-health project. E-health expenses incurred during the year are as follows:

	2009	2008
	\$	\$
Salaries and benefits	288,600	163,585
Consulting services	145,960	103,875
Accommodation and administration	48,001	-
Supplies and other	1,139	7,540
	483,700	275,000

b) Emergency Response – Alternate Level of Care (ER-ALC)

The LHIN received funding of \$33,300 for the Emergency Response – Alternate Level of Care project in the 2009 fiscal year. The following are the expense details from last fiscal year:

	2009	2008
	\$	\$
Salaries and benefits	29,364	-
Accommodation and administration	3,652	-
Supplies and other	284	-
	33,300	-

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10. c) Aging at Home

The LHIN entered into a Shared Cost Agreement with the Central CCAC for up to \$364,000 to deliver incremental costs associated with Aging at Home Planning incurred on behalf of the CCAC for the 2009 fiscal year (2008 - \$263,000). Expenses incurred during the year are as follows:

	2009	2008
	\$	\$
Salaries and benefits	233,064	93,783
Public relations	13,449	17,279
Consulting services	9,950	142,586
Supplies	218	929
Other	7,855	8,423
Recoveries	(264,536)	-
	-	263,000

d) Aboriginal initiative

The LHIN received funding of \$47,088 (2008 - \$10,000) related to the Aboriginal Planning initiative. Expenses incurred during the year are as follows:

	2009	2008
	\$	\$
Consulting services	46,167	10,000
Supplies and Other	921	-
	47,088	10,000

e) Governance toolkit

The LHIN did not receive any further funding in the 2009 year (2008 - \$50,000) from the MOHLTC towards a multi-LHIN project related to the creation of a Governance Toolkit. The 2008 Funding was primarily spent on consulting services.

f) Emergency department (ED) lead project

The LHIN received funding of \$75,000 (2008 - \$31,300) related to the ED Lead project. ED Lead project expenses incurred during the year are as follows:

	2009	2008
	\$	\$
Salaries and benefits	15,000	6,000
Consulting services	60,000	25,000
Supplies	-	300
	75,000	31,300

g) Wait time funding

In 2008, the LHIN received \$70,000 related to planning for the wait time projects. The funding was unspent and returned to the MOHLTC as year end surplus.

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11. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2009	2008
	\$	\$
Salaries and benefits	2,678,888	2,241,011
Occupancy	221,466	237,268
Amortization	164,044	120,381
Shared services	300,000	300,000
Public relations	109,350	116,301
Consulting services	288,534	128,474
Supplies	67,401	46,961
Board expenses	200,221	140,676
Mail, courier and telecommunications	53,132	56,381
Other	154,232	169,535
	4,237,268	3,556,988

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 23 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2009 was \$200,455 (2008 - \$160,859) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2008. At that time, the plan was 97% funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

14. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

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